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DEPARTMENT OF HEALTH

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HEALTH ADVISORY: INFLUENZA PREVENTION AND CONTROL 2005-06
Please distribute immediately to the Infection Control Department, Medical Director, Emergency Department, Employee Health, and all patient care areas.

The New York State Department of Health (NYSDOH) is providing this advisory on influenza-related activities to assist public and private health care providers in preparing for the 2005-06 influenza season. This advisory summarizes some of the key points on:

1. Recommendations of the Advisory Committee on Immunization Practices

The Centers for Disease Control and Prevention (CDC) published the yearly recommendations of the Advisory Committee on Immunization Practices (ACIP) in July 2005 (*Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices*. MMWR, Vol. 54, No. RR-8). The report can be accessed at http://www.cdc.gov/mmwr/PDF/rr/rr5408.pdf

The 2005 recommendations include several principal changes or updates:

- ACIP recommends that persons with any condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration be vaccinated against influenza.

- ACIP emphasizes that all health-care workers should be vaccinated against influenza annually, and that facilities that employ health-care workers be strongly encouraged to provide vaccine to workers by using approaches that maximize immunization rates.
- Use of both available vaccines (inactivated and Live Attenuated Influenza Vaccine [LAIV]) is encouraged for eligible persons every influenza season, especially persons in recommended target groups. During periods when inactivated vaccine is in short supply, use of LAIV is especially encouraged when feasible for eligible persons (including health-care workers) because use of LAIV by these persons might considerably increase availability of inactivated vaccine for persons in groups at high risk.
- The CDC and other agencies will assess the vaccine supply throughout the manufacturing period and will make recommendations preceding the 2005-06 influenza season regarding the need for tiered timing of vaccination of different risk groups. (See Section 4, Recommendations for Prioritization during the 2005-06 Influenza Season.)

Both the inactivated influenza vaccine and LAIV can be used to reduce the risk for influenza. LAIV is approved for use among healthy persons aged 5-49 years. Inactivated influenza vaccine is approved for persons aged ≥ 6 months, including those with high-risk conditions (See the following sections on inactivated influenza vaccine and LAIV).

Target Groups for Vaccination

Persons at Increased Risk for Complications

Vaccination with inactivated influenza vaccine is recommended for the following persons who are at increased risk for complications from influenza:

- persons aged ≥ 65 years;
- residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions;
- adults and children who have chronic disorders of the pulmonary or cardiovascular systems, including asthma (hypertension is not considered a high-risk condition);
- adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications or by human immunodeficiency virus [HIV]);
- adults and children who have any condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration;
- children and adolescents (aged 6 months-18 years) who are receiving long-term aspirin therapy and, therefore, might be at risk for experiencing Reye syndrome after influenza infection;
- women who will be pregnant during the influenza season; and
- children aged 6-23 months.

Persons Aged 50-64 Years

Vaccination with inactivated influenza vaccine is recommended for persons aged 50-64 years because this group has an increased prevalence of persons with high-risk conditions.

Persons Who Can Transmit Influenza to Those at High Risk
Persons who are clinically or subclinically infected can transmit influenza virus to persons at high risk for complications from influenza. Decreasing transmission of influenza from caregivers and household contacts to persons at high risk might reduce influenza-related deaths among persons at high risk. All health-care workers should be vaccinated against influenza annually. In addition to health-care workers, additional groups that can transmit influenza to high-risk persons and that should be vaccinated include:

- employees of assisted living and other residences for persons in groups at high risk;
- persons who provide home care to persons in groups at high risk; and
- household contacts (including children) of persons in groups at high risk.

In addition, because children aged 0-23 months are at increased risk for influenza-related hospitalization, vaccination is recommended for their household contacts and out-of-home caregivers, particularly for contacts of children aged 0-5 months, because influenza vaccines have not been approved by FDA for use among children aged < 6 months.

Healthy persons aged 5-49 years in these groups who are not contacts of severely immunosuppressed persons can receive either LAIV or inactivated influenza vaccine. (See Live, Attenuated Influenza Vaccine Recommendations). All other persons in this group should receive inactivated influenza vaccine.

Healthcare Workers
All healthcare workers should be vaccinated against influenza annually. Facilities that employ healthcare workers are strongly encouraged to provide vaccine to workers by using approaches that maximize vaccination rates. This will protect healthcare workers, their patients, and communities, and will improve prevention of influenza-associated disease, patient safety, and will reduce disease burden. Influenza vaccination rates among healthcare workers should be regularly measured and reported. Although vaccination rates for healthcare workers are typically <40%, with moderate effort, organized campaigns can attain higher rates of vaccination among this population. Physicians, nurses, and other workers in both hospital and outpatient-care settings, including medical emergency-response workers (e.g., paramedics and emergency medical technicians), should be vaccinated, as should employees of nursing home and chronic-care facilities who have contact with patients or residents.

Close Contacts of Persons at High Risk for Complications from Influenza
Close contacts of persons at high risk for complications from influenza should receive influenza vaccine to reduce transmission of wild-type influenza viruses to persons at high risk. ACIP has not indicated a preference for inactivated influenza vaccine use by health-care workers or other persons who have close contact with persons with lesser degrees of immunosuppression (e.g., persons with diabetes, persons with asthma taking corticosteroids, or persons infected with HIV) or for inactivated influenza vaccine use by health-care workers or other healthy persons aged 5-49 years in close contact with all other groups at high risk. Use of inactivated influenza vaccine is preferred for vaccinating household members, health-care workers, and others who have close contact with **severely** immunosuppressed persons (e.g., patients with hematopoietic stem cell transplants) during those periods in which the immunosuppressed person requires care in a protective environment. The rationale for not using LAIV among health-care workers caring for such patients is the theoretical risk that a live, attenuated vaccine virus could be transmitted to the severely immunosuppressed person. If a health-care worker receives LAIV, that worker

should refrain from contact with severely immunosuppressed patients for 7 days after vaccine receipt. Hospital visitors who have received LAIV should refrain from contact with severely immunosuppressed persons for 7 days after vaccination; however, such persons need not be excluded from visitation of patients who are not severely immunosuppressed.

Live Attenuated Influenza Vaccine (LAIV)

LAIV is an option for vaccination of healthy persons aged 5-49 years, including most health-care workers and other persons in close contact with groups at high risk and those wanting to avoid influenza. During periods when inactivated vaccine is in short supply, use of LAIV is encouraged when feasible for eligible persons (including health-care workers) because use of LAIV by these persons might increase availability of inactivated vaccine for persons in groups at high risk. Possible advantages of LAIV include its potential to induce a broad mucosal and systemic immune response, its ease of administration, and the acceptability of an intranasal rather than intramuscular route of administration.

Persons Who Should <u>Not</u> Be Vaccinated with LAIV

The following populations should not be vaccinated with LAIV:

- persons aged < 5 years or those aged ≥ 50 years;
- persons with asthma, reactive airways disease, or other chronic disorders of the pulmonary or cardiovascular systems; persons with other underlying medical conditions, including such metabolic diseases as diabetes, renal dysfunction, and hemoglobinopathies; or persons with known or suspected immunodeficiency diseases or who are receiving immunosuppressive therapies;
- children or adolescents receiving aspirin or other salicylates (because of the association of Reye syndrome with wild-type influenza infection);
- persons with a history of Guillain Barre Syndrome;
- pregnant women; or
- persons with a history of hypersensitivity, including anaphylaxis, to any of the components of LAIV or to eggs.

Personnel Who May Administer LAIV

Low-level introduction of vaccine viruses into the environment is likely unavoidable when administering LAIV. The risk for acquiring vaccine viruses from the environment is unknown but likely to be limited. Severely immunosuppressed persons should not administer LAIV. However, other persons at high risk for influenza complications may administer LAIV. These include persons with underlying medical conditions placing them at high risk or who are likely to be at risk, including pregnant women, persons with asthma, and persons aged ≥ 50 years.

<u>2. Supply of Influenza Vaccine</u>

The following are estimates of doses expected to be produced by each vaccine manufacturer, and are current as of September 13, 2005:

- Sanofi Pasteur (Aventis-Pasteur):
    - 60 million doses of trivalent inactivated vaccine (TIV), Fluzone
    - 10 of the 60 million doses will be distributed in December or later.

- Chiron:
  - 18-26 million doses of TIV, Fluviron
  - On August 31, 2005, Chiron Corporation announced favorable results of a Food and Drug Administration (FDA) inspection of their influenza vaccine manufacturing facility. This means that Chiron can proceed with its efforts to return its influenza vaccine to the U.S. market for the 2005-06 influenza season. The vaccine must receive supplemental regulatory approvals and an annual formal product release before delivery to customers.

- GlaxoSmithKline:
  - 8 million doses of TIV, Fluarix
  - GSK has obtained approval from the FDA for licensure of its influenza vaccine, Fluarix, on August 31, 2005.

- MedImmune:
  - 3.0 million doses of live attenuated inactivated vaccine (LAIV), FluMist

Most of the anticipated inactivated Sanofi Pasteur vaccine has been pre-booked, though the company continues to have some preservative-free syringes available. FluMist also continues to be available for pre-booking.

3. Distribution of Influenza Vaccine

Sanofi Pasteur, GlaxoSmithKline, and MedImmune have all begun shipping vaccine. The following FDA website provides up-to-date information on influenza vaccine lots that have been released by the FDA: http://www.fda.gov/cber/flu/flulot090705.htm

Purchasers of large orders from Sanofi Pasteur will receive 3-4 partial orders by December to complete the delivery of their order. Smaller orders will be delivered in one amount.

GlaxoSmithKline has negotiated a contract with two distributors to distribute vaccine. Two-thirds of its product will go to a distributor that serves primarily nursing homes, hospitals and large private practices, and one-third to a distributor that focuses on private physicians.

Chiron is planning to distribute vaccine through its usual distribution network, once necessary approvals are obtained from the FDA.

FDA Allows Influenza Vaccine Redistribution During the 2005-06 Season

Again this year, the FDA has agreed to allow providers to redistribute influenza vaccine between/among themselves to remedy any maldistribution that may occur as a result of delays in vaccine distribution or shortages. The FDA statement can be found at:

http://www.cdc.gov/flu/professionals/vaccination/reallocation0506season.htm

4. Recommendations for Prioritization of Influenza Vaccine

Due to the fact that uncertainties still remain regarding the doses and distribution of influenza vaccine, healthcare providers should concentrate influenza vaccination efforts on the following groups during September and October of 2005:

- persons aged ≥65 years
- residents of long-term care facilities
- persons aged 2--64 years with comorbid conditions
- children aged 6--23 months
- pregnant women
- health-care personnel who provide direct patient care
- household contacts and out-of-home caregivers of children aged <6 months

Providers may opt to vaccinate individuals not in the above groups if the opportunity arises (e.g., during a routine medical visit). However, broader community immunization efforts to vaccinate healthy individuals should not begin until late October or early November, or at such time as it becomes clear that sufficient influenza vaccine supplies will be available.

5. Ordering Influenza Vaccine

Health care providers who have not ordered vaccine should do so as soon as possible to ensure timely receipt of vaccine.

- MedImmune still has quantities of its live attenuated vaccine (FluMist) available for pre-booking.
- Sanofi Pasteur continues to pre-book orders for its pediatric influenza vaccine in the pre-filled syringe presentation.
- Distributors for the influenza vaccines produced by Chiron and GlaxoSmithKline have been taking orders for those products. Prospective customers should check with these distributors regarding availability.
- Providers may need to explore several potential sources to find influenza vaccine. Providers who experience difficulty obtaining vaccine for persons at high risk should contact their local health department (LHD) for assistance.

Ordering Influenza Vaccine through the New York Vaccines for Children Program

Influenza vaccine is available through the New York Vaccines for Children (NY VFC) Program for eligible children who are considered high risk, up to their 19th birthday. The high-risk population is defined as:

- children aged 6-23 months;
- children who have heart disease, lung disease (including asthma and cystic fibrosis), kidney disease, immunosuppression (including immunosuppression caused by medication and radiation), or hemoglobinopathies or chronic metabolic disease (including diabetes mellitus);
- women (up to their 19th birthday) who are pregnant during the influenza season; and children who are receiving long-term aspirin therapy and therefore might be at risk for developing Reye syndrome after influenza.

In addition, the following group is eligible:

- children aged 2-18 years who are household contacts of persons in high-risk groups (including household contacts of children aged 0-23 months).

NY VFC-enrolled providers outside New York City may order influenza vaccine by calling the 1-800-KID SHOTS (1-800-543-7468) number. Providers within New York City should call 212-447-8175. Providers not enrolled who are interested in doing so may call these same numbers to receive NY VFC information and a registration packet.

6. 2005-06 Vaccine Information Statements

CDC's 2005-06 Vaccine Information Statements (VIS) for inactivated influenza vaccine and LAIV are available at http://www.cdc.gov/nip/publications/VIS/default.htm. These statements should be provided to all adult recipients and the parents or guardians of minor recipients prior to administering the vaccine.

7. Promoting Influenza and Pneumococcal Immunizations to High-Risk Groups

NYSDOH is committed to promoting influenza and pneumococcal immunizations to high-risk groups. In this regard, the Department endorses the work of regional adult immunization coalitions throughout the state. Providers interested in learning more about the activities of coalitions in their area are encouraged to contact NYSDOH's Immunization Program at 518-473-4437. In partnership with the New York State Office for the Aging, NYSDOH maintains a web site, at www.flu.state.ny.us, which provides extensive information about influenza immunization to both providers and the public. The web site includes information about flu clinic schedules and locations through Internet links to local and regional adult immunization coalitions. Additional provider resources include a listing of influenza vaccine distributors, sample standing orders, and educational materials for providers and patients. Upon accessing the web site, providers should double click on **Provider** whereupon they will be prompted for a user name (**aim**) and password (**flu**).

Many of the individuals at risk for serious influenza infection may also be at risk for pneumococcal disease and should be considered for pneumococcal vaccine in accordance with current ACIP guidelines described in the April 4, 1997, *Morbidity and Mortality Weekly Report (MMWR)*. When indicated, influenza and pneumococcal vaccines should be administered simultaneously at different sites.

8. Long-Term Care Resident and Employee Immunization Act

Since April 1, 2000, New York State Public Health Law has required nursing homes, adult homes, adult day health care programs, enriched housing programs, and any residence housing five or more persons over age 65 to provide or arrange for influenza vaccination annually to their residents and employees. Vaccination helps protect the elderly (who are more likely to suffer severe health consequences from influenza) and helps prevent staff from becoming infected and transmitting influenza to this vulnerable population. Facilities must document receipt of annual immunization, deferral, or refusal of immunization for residents and staff, and must submit an annual report to the NYSDOH of the numbers of residents and staff vaccinated and not

vaccinated. Additional information regarding the law and the annual report required by the law is available at www.health.state.ny.us/nysdoh/infection/ltc_act/index.htm.

9. Influenza Reporting Requirements

From October 2, 2005, through May 14, 2006, the NYSDOH will conduct statewide influenza surveillance and report the weekly influenza activity to the CDC. As of December 1, 2004, on an emergency basis, laboratory-confirmed influenza was added to and continues to remain on the reportable disease list in New York State (Section 2.1 of the New York State Sanitary Code). The addition of laboratory-confirmed influenza to the list of reportable conditions in New York State has greatly enhanced influenza reporting and surveillance efforts. The following reporting requirements have resulted in local health departments and the NYSDOH having more comprehensive and complete information on influenza activity.

Laboratory-confirmed influenza:

- Positive influenza test result reporting from laboratories that electronically submit files through the Electronic Clinical Laboratory Reporting System (ECLRS) using ASCII or HL7 formats and LOINC coding is continuing.
- Laboratories that do not use the ECLRS reporting methods above may also report positive influenza test results, but at this time are not being asked to initiate reporting.
- Laboratories entering data directly into the ECLRS Web page may report influenza positive test results using the drop-down menu for reportable conditions.
- The ECLRS Help Desk (866-325-7743) is available to answer questions and assist laboratories using ECLRS or laboratories that would like to start reporting electronically.
- At this time, medical providers do not need to report individual cases of influenza or submit a confidential case report (DOH-389) to the local health department except for fatal pediatric influenza illness (see below).

Pediatric deaths due to confirmed or suspected influenza:

- Medical providers and medical examiners should report to the local health department:
  - Cases of fatal influenza illness in pediatric patients less than 18 years of age
  - Any pediatric death resulting from a clinically compatible illness
- Laboratory testing for influenza A and B viral infection may be performed on pre- or post-mortem clinical specimens. The local health department can advise on appropriate laboratory testing and can facilitate referral of specimens as needed to NYSDOH Wadsworth Center Laboratory.

Weekly reporting of the number of patients hospitalized with laboratory-confirmed influenza:

- Hospitals are required to report each Wednesday on the Hospital Emergency Response Data System (HERDS) for the previous week ending Saturday midnight the number of newly identified hospitalized laboratory-confirmed influenza cases by age group.
  - The age groups are to be aggregated into the following categories:
    - 0-23 months
    - 2 to 18 years
    - 19 to 64 years
    - >64 years

- Patients should be reported only once when first diagnosed.
- Include both community-acquired and nosocomial cases of influenza.
  - For nosocomial acquisition of influenza, the Health Care Facility Infection Control (Nosocomial) Report (DOH-4018) is to be submitted to the NYSDOH Regional Epidemiology Program by fax at (518) 408-1745.
- Reporting will be initiated Wednesday October 12, 2005, for the week starting Sunday October 2 and ending Saturday midnight October 8, 2005.
- Weekly reporting for the 2005-2006 influenza season will continue through May 24 2006.

- If you have any technical difficulties with accessing or using HERDS, please contact Lisa Beaudoin at (518) 473-1809 or John Kushner at (518) 408-5163.

Reporting of outbreaks of influenza by facilities and institutions:
Facilities and institutions, including elementary and secondary schools, colleges, adult homes, correctional facilities, psychiatric facilities, and OMRDD facilities, should report, by telephone, any outbreaks of influenza-like illness to the LHD, which in turn is required to notify the NYSDOH. State-operated facilities and institutions must also report, by telephone, to the NYSDOH.

Reporting of nosocomial influenza by hospitals and nursing homes:
Hospitals and nursing homes should report nosocomial influenza to the LHD, as well as to the NYSDOH. This includes one or more laboratory-confirmed nosocomial cases of influenza or an increased incidence of nosocomial febrile respiratory illness. An increased incidence would include an increase over the baseline level of febrile respiratory illness, or a cluster of 2-3 patients or residents on one unit with febrile respiratory illness. Cases that were not acquired at your facility but may involve a threat to a unit or facility should also be discussed with your Regional Epidemiologist. Examples would include a case of community-acquired influenza in a patient in a high-risk setting, such as an organ or hematopoietic stem cell transplant (HSCT) unit; or a case of healthcare-associated influenza that was acquired at another facility. The hospital or nursing home should complete NYSDOH Nosocomial Report Form DOH-4018 (available at http://www.nyhealth.gov/nysdoh/infection/infecreport.pdf) and fax it to the NYSDOH Regional Epidemiology Program, central office, at (518) 408-1745. The appropriate regional office will follow up with the hospital or nursing home making the report.

10. Influenza Outbreak Control in Health Care Facilities

When an increased incidence of febrile respiratory illness is identified, an attempt should be made to identify the specific viral agent as soon as possible in order to provide diagnostic information, guide control measures, and determine if antiviral use is indicated. Several other respiratory viruses, including respiratory syncytial virus, adenovirus, and parainfluenza virus, frequently co-circulate with influenza viruses during the influenza season, and testing is required to determine which of these agents may be causing the outbreak.

Respiratory specimens should be obtained from six to 12 patients or residents who are ill with respiratory symptoms. Nasal aspirates or nasopharyngeal swabs are the specimens of choice due to their greater likelihood of capturing influenza viruses in the upper respiratory tract. Specimens should be submitted to a private or commercial laboratory capable of performing

rapid antigen testing **as well as** viral culture for the various viral agents. Culture is recommended due to the relative insensitivity of some rapid tests in detecting influenza. (Requests for follow-up culture on negative rapid antigen testing may have to be made in writing for some laboratories.) Facilities are encouraged to identify private or commercial laboratories capable of performing such testing before the onset of influenza season. Testing of specimens at the NYSDOH's Wadsworth Center virology laboratory is available on a limited basis and must be arranged through the NYSDOH Regional Epidemiology Program (see list of regional offices below).

A checklist of the suggested procedures for follow-up of an increased incidence or outbreak of respiratory illness is included as Attachment 1. A respiratory illness line list form for recording information about cases is available at:
http://www.health.state.ny.us/nysdoh/infection/doh-496.pdf.

If facilities wish to consult with an epidemiologist prior to faxing their nosocomial report to the NYSDOH Regional Epidemiology Program (518-408-1745), they are encouraged to call the NYSDOH Regional Epidemiologist in their area. Facilities in New York City are encouraged to call the Influenza Surveillance Coordinator in the Communicable Disease Program at the New York City Department of Health and Mental Hygiene (NYCDOHMH) at (212) 442-9050.

The CDC and NYSDOH recommend the use of antiviral prophylaxis when influenza occurs in a long-term care facility. Detailed recommendations can be found on pages 22-30 of the 2005-06 ACIP Recommendations. Use of antiviral prophylaxis has aborted influenza outbreaks in many long-term-care facilities in New York State during previous influenza seasons.

CDC has published extensive guidance documents, which the NYSDOH endorses, regarding control of nosocomial influenza in acute and long-term care settings. CDC's guidance document, *Detection and Control of Influenza Outbreaks in Acute Care Facilities*, is available at http://www.cdc.gov/ncidod/hip/INFECT/flu_acute.htm. CDC's guidance document, *Infection Control Measures for Preventing and Controlling Influenza Transmission in Long-Term Care Facilities* is available at http://www.cdc.gov/flu/professionals/infectioncontrol/longtermcare.htm.

11. Influenza Surveillance

Local and state health department personnel conduct active surveillance during the influenza season. This activity includes monitoring of reports of laboratory testing, reports of influenza-like illness by members of the New York State Influenza Sentinel Physician Surveillance Network, reports of nosocomial influenza from hospitals and nursing homes, and reports of community or institutional influenza outbreaks from LHDs. Using these various sources, the NYSDOH provides a statewide influenza surveillance map and other influenza-related information on its public web site: http://www.health.state.ny.us/nysdoh/flu/index.htm.
CDC provides nationwide influenza surveillance on its public website:
www.cdc.gov/ncidod/diseases/flu/fluvirus.htm**.**

Inquiries or questions concerning influenza recommendations or outbreak control should be directed to your local health department, the NYSDOH Regional Epidemiology Program office in your area, or the NYSDOH Regional Epidemiology Program central office in Albany:

NYSDOH Western Regional Office:
Buffalo (716) 847-4503

NYSDOH Central New York Regional Office:
Syracuse (315) 477-8166

NYSDOH Capital District Regional Office:
Troy (518) 408-5396

NYSDOH Metropolitan Area Regional Office:
New Rochelle (914) 654-7149

NYSDOH Regional Epidemiology Program:
Albany (518) 473-4439

Influenza Surveillance Coordinator, New York City Department of Health and Mental Hygiene:
New York City (212) 442-9050

Attachments

Attachment 1: Checklist of suggested procedures for follow-up of respiratory disease outbreaks in health care facilities

CHECKLIST OF SUGGESTED PROCEDURES FOR FOLLOW-UP OF RESPIRATORY DISEASE OUTBREAKS IN HEALTH CARE FACILITIES

1. When multiple cases of febrile respiratory illness are identified in a health care facility, symptomatic patients should be confined to their rooms or restricted to the affected unit until more information is known.

2. Notify the NYSDOH Regional Epidemiology Program of the outbreak by completing the NYSDOH Nosocomial Report Form DOH-4018 and faxing it to (518) 408-1745 or calling (518) 473-4439. Outbreaks also need to be reported to the local health department (LHD). The medical director or the infection control practitioner may also wish to discuss the situation with the NYSDOH Regional Epidemiologist in their area. Health department epidemiologists are pleased to offer consultation as soon as an illness cluster is identified.

3. Use the NYSDOH Respiratory Illness Line List form to record as much information as possible about individual ill patients. The line list may be faxed a day or two after the nosocomial report. Starting and maintaining a line list helps track the progress of an outbreak.

4. Monitor staff absenteeism for respiratory illness.

5. If a viral agent is suspected, the medical director or infection control practitioner should obtain respiratory specimens from six to 12 patients with recent (within the past 48 hours) onset of fever. Nasal aspirate or nasopharyngeal swab specimens are the specimens of choice.

6. Specimens should be submitted to an appropriate laboratory and tested by both rapid antigen detection and viral culture. (Because rapid antigen testing is less sensitive than culture, culture should also be performed). Rapid antigen testing must be able to differentiate between influenza type A and type B. If a private or commercial laboratory is not available, after consultation with the NYSDOH Regional Epidemiologist, a maximum of six specimens may be submitted to the NYSDOH Wadsworth Center virology laboratory for testing.

7. Implement the following control measures:

- ☐ Ensure ill employees do not work.
- ☐ Minimize floating of staff.
- ☐ Provide inservice training session for staff on infection control measures for respiratory outbreaks.
- ☐ Notify receiving facility of the outbreak when transfers occur.
- ☐ Additionally, when one or more specimens has tested positive for influenza by rapid antigen test or culture:
  - ♦ Confine ill patients to their room and place on droplet precautions. (Useful reference on droplet precautions is: www.cdc.gov/ncidod/hip/INFECT/isolation.htm).
  - ♦ Use influenza antiviral prophylactic medication in accordance with CDC guidelines (ACIP Recommendations, pages 22-30).
  - ♦ If the outbreak involves severe illness and complications, confine asymptomatic patients to their rooms until placed on antiviral prophylactic medication for 24 hours.
  - ♦ Place new admissions on antiviral prophylactic medication during the outbreak period.
  - ♦ Antiviral **prophylaxis** should be given for at least 14 days. If surveillance indicates that new cases continue to occur, prophylaxis should be continued until seven days after the onset of the last identified case.
  - ♦ Antiviral **treatment** for symptomatic patients should be given for five days.
  - ♦ Encourage increased hand hygiene by staff and patients.
  - ♦ Re-offer influenza vaccine to unvaccinated patients and staff.
  - ♦ Notify visitors that influenza is occurring in the facility.